BOGART (W.G.)

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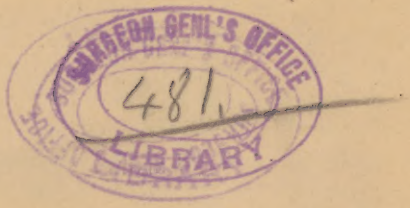

THE LACERATED CERVIX.

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There is no department of medicine that has received more attention or made more rapid progress in the last quarter of a century than the branch of gynæcology, and it has been only through the untiring energy and labors of such men as McDowell, Sims, Thomas, and our own much esteemed Battey, that today we stand as American surgeons at the head of the profession of medicine.

It is my intention today, to speak of a not infrequent accident, and especially the treatment, for which we are indebted to Dr. Emmett, of New York, "The Lacerated Cervix." It was not until after he had written his paper in 1862, entitled "Principles and Practice of Gynæcology," that this subject has attracted any special attention in the profession; but especially in his first paper on this subject in 1869, we find that the attention of the practitioner has been attracted as much, if not more, to this subject than any other. It has been found that by its existence many pathological conditions have followed as a natural result. At first, of course, we have nothing but a simple wound, which may heal more or less rapidly, according to the greater or less amount of cleanliness. Under very favorable conditions we may have union to take place by first intention, but a perfect union, however, is very rare. There is usually a certain amount of cicatricial tissue under circumstances of this kind, which has a less supply of blood than we normally find, and the nerve supply is found in most cases to be either abnormally furnished, or there is a marked exaltation of function. We frequently find the cervix painfully sensitive to the touch, which is due either to the jarring of a nerve, or likely to a cellulitis or peritonitis existing. With these conditions we may have hypertrophy, cystic degeneration, bringing along with it a multiplicity of symptoms, which by many are diagnosed as diseases. The symptoms by which we may suspect, or even with some degree of certainty diagnose, a laceration, are many. I may say that laceration may exist for a

time without exciting enough attention for the patient to know that anything with the pelvic organs is wrong, but it is not until after it has reached a chronic form that the symptoms begin to point to the pelvis as the seat of trouble. We find this patient pale and haggard, and she complains of dragging sensations in the hips and loins. Most often she will have a sanguineous discharge, or of leucorrhœa, no appetite, digestion variable, despondent, sleep disturbed and bowels constipated. Many of you may think that I have overdrawn the line of symptoms pointing to a laceration, but when we consider the many pathological conditions which likely exist at the same time, we are not surprised. Subinvolution, areola, hyperplasia, often some of the displacements, together with cervical degeneration, with an existing vaginitis, urethritis, and along with these conditions probably menstrual disturbances, in some instances amenorrhœa, while at other times we may have menorrhagia, or metorrhagia, which is by far the most frequent. Often repeated miscarriages is another condition which is not at all uncommon, while on the other hand we may have sterility as the result of laceration. There is a long line of nervous conditions which is either directly or indirectly due to this condition.

Dr. Emmett says the importance of a lacerated cervix cannot be exaggerated, since one-half of all the ailments of those who have borne children are to be attributed to the laceration of the cervix. This statement is substantiated by men of equal eminence, as well as by many general practitioners; and it is a statement not to be disputed, that the lacerated cervix together with the many complications which are certain to follow, is the source of much suffering, disappointment, and I might say, unhappy homes.

Since this is true, let us see what can be done for the unfortunate individual who may be suffering from this condition.

Understanding it as we do, we see that we have a physical wreck as well as a local lesion. For convenience let us divide the treatment into preventive, preparatory and operative.

Preventive treatment more properly belongs to the obstetrician, and if prevented at all must be prevented at the time of confinement. We all know that often a laceration of the cervix cannot be avoided, no matter how skillful we be; but we do know that there are some things done often which make it very much more liable to occur. The administration of ergot, the untimely use of the forceps, the rapid dilation of the os by artificial means, and I might say by a general unskillful and meddlesome manipulation.

As to the preparatory treatment, much can be said, for in the proper preparation of our patient depends the entire success of labor; and just as the wise farmer would first prepare his soil before sowing his seed, so a wise physician will first prepare the system before attempting to repair this local lesion.

General tonics, nutritious diet, open air, appropriate laxatives and local preparatory treatment should command our attention. Iron, quinine and strychnia, together with vegetable tonics, would be found very useful, a tonic laxative being required in most cases, as constipation is one of the conditions which usually exist.

As to the preparatory local treatment, much can be done by the use of wool or cotton tampon, the wool being preferable. The tampon may be soaked in glycerine, boroglyceride or glycerotannin, glycerine and iodine. Blood letting by puncture, Churchill's tincture of iodine, iodized phenol, and the use of a large amount of hot water for their stimulating effects, would be some of the means preparatory to the operation, if any operation be necessary.

While I would not attempt to detract from the operation any of its usefulness, when needed, I am opposed to the too frequent use of the knife in these cases, just as I am in many others. My reading, as well as my experience, teaches me that it is best in a large per cent. of cases to try other measures first. Dr. W. Gill Wylie said that a lacerated cervix should not be sewed up until it gives rise to symptoms; and that when it does produce symptoms, there is some disease behind that needs treatment. Dr. Paul F. Munde, in the same discussion, said that he never considered a laceration with regard to operation unless it produced symptoms. Its mere existence does not call for sewing up, no matter how large it may be, or how much everted. Dr. A. E. Currier says: "I decline more and more to perform the operation." Dr. Emmett says: "I think sometimes that more harm than good has been done by the operation, although in so many cases there is no operation that can take its place or accomplish so much." He further states that where we have subinvolution or a thickened condition of the broad ligaments, that the case must be properly prepared before the cervix should be operated upon, and until the preparatory treatment has been carried out it is impossible to say what cases require operation and what do not. Dr. Battey corroborates the above statement as to frequency of operating upon the cervix, and states that where he used to operate a number of times, he now only operates upon the cervix a few times.

But that we have cases that require trachelorrhaphy is certain. The day before the operation, it is good practice to thoroughly move the bowels with a laxative. The patient may be anæsthetized; however, this is not necessary. The patient is placed in a Sims' position and the vagina dilated as large as necessary to bring the cervix in view. The neck is seized with a Vulcellum forceps and drawn until the lips can be transfixed from before backward, with a strong needle armed with a double thread. The threads are drawn through far enough to form two loops; these loops are left long enough to pass out of the vagina several inches, and by them we are able to completely fix the cervix, or change the position at will. The loops may be held up by an assistant; a small tenaculum may be used to hold the cervix in position.

These preparatory steps having been taken, the operator seizes the edge of the laceration with the tenaculum and pares off all the cicatricial membrane. The entire cicatricial surface should be removed, seeing well that the angles are thoroughly pared. After this is completed and the hæmorrhage has been overcome, we take our stitches, beginning about one-eighth of an inch from the incision on either side of the flap. The needle is passed perpendicularly through to a point that will include the same distance in the endocervical membrane. To this thread should be attached a silver wire eight or ten inches long drawn through and held by an assistant, until all are placed in. Before twisting the wire the edges of the wound should be cleansed of all clots, and the wires should then be twisted evenly Catgut, silkworm gut or silk thread are equally as good as the wire. After the operation the vagina should be thoroughly cleansed and the patient placed in bed. Of course antiseptic measures have been carried out fully.

It would be well here to consider some of the causes of failure in obtaining a perfect result.

First, an imperfect performance of the operation. But the most frequent cause of failure is an imperfect preparation of our patient. These, with the management of our patient after operations, are the chief causes.

The patient must remain quiet, and the bowels should not be moved for at least three or four days. Strict attention to the evacuation of the bladder; light diet, and for the most part liquid; the vagina kept clean by warm water injections two or three times per day. The sutures should be removed in about ten days, and the patient allowed to take moderate exercise for a time.